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AUTHOR	Croley, H. T.
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ABSTRACT

A profile of the United Arab Republic is sketched in this paper. Emphasis is placed on the nature, scope, and accomplishments of population activities in the country. Topics and sub-topics include: location and description of the country; population (size, growth patterns, age structure, urban/rural distribution, ethnic and religious composition, migration, literacy, economic status, future trends); population growth and socio-economic development (relationships to national income, size of the labor force, agriculture, social welfare expenditures); history of population concerns; population policies; population programs (objectives, organization, operations, research and evaluation); private efforts in family planning; educational and scientific efforts in population; and foreign assistance for family planning activities. (RH)

Country Profiles

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UNITED ARAB REPUBLIC

THIS profile was prepared by Dr. H. T. Croley, Program Advisor, Population, the Ford Foundation, Cairo, United Arab Republic. It is published here with the permission and approval of Dr. Abdou M. Sallam, Minister of Public Health, United Arab Republic.

Location and Description[1]

The United Arab Republic, or what is known to many as Egypt, is in the northeast corner of the African continent and is linked to Asia by the Sinai peninsula. For the most part the country is desert outside the Valley of the Nile. Only 3.5 per cent of the land is inhabited, and only 2.5 per cent is capable of producing crops. The total area of the country is 386,000 square miles (about 1,000,000 square kilometers).

The Mediterranean coastal fringe receives rain for about six months of the year but elsewhere there are only light showers or no rain at all. It is hot during the day in spring and summer and very hot in the south, but usually the temperature falls sharply after sunset. Autumn and winter are mild by day and cool at night. There are people in the oasis of the Western Desert, the largest center of population being at Fayoum. The only other major center of population outside the Nile Valley is on the Isthmus of Suez, but even this community is watered artificially from the Nile and is man-made to meet the needs of the Suez Canal.

The Egyptian people have been and still are dependent upon the life-giving qualities of the Nile for survival. In the past the systematic utilization of the Nile compelled the people to create an advanced social organization, from which evolved the first nation-state. The High Dam at Aswan holds promise for changing the U.A.R. from an agrarian state into a modern industrial-agrarian state.

Population

Size and Growth Patterns

Size. The population of the U.A.R. has tripled in the last 70 years, doubled in the last 30 years and according to the census was 30,075,858[2] in 1966. By December 1968 it had grown to an estimated 32,025,000.[3] The population density of the inhabited area (3.5 per cent of the total area) is almost 2,400 per square mile.

Number of households. The 1966 census reports 5,705,671 households with an average household size of 5.27 persons.[4]

Based on preliminary reports from the 1966 census there were 4,917,000 married women in the 15–49 age group and 4,406,000 from 15 through 44.[5]

Growth patterns. The recorded birth rate has fluctuated between 39.3 and 44 per 1,000 over the past 60 years, with 39.3 the estimated rate for 1967.[6] During the same period the death rate dropped, almost steadily, from 26 to 14.3 with a corresponding increase in the growth rate from 17 to 25.4 per thousand.[7]

Rural/Urban Distribution

The U.A.R. is still primarily rural but there has been a gradual decrease in the rural/urban ratio from 79:21[8] in 1917 to about 60:40 in 1966.[9] There are fourteen cities with populations greater than 100,000; in 1966 Cairo had 4,219,853, Giza (which adjoins Cairo) 571,249, and Alexandria 1,801,056.[10]

The rural/urban differential in birth and fertility rates found in some coun-

[1] Based primarily on: Tom Little, *Modern Egypt* (New York: Frederick A. Praeger, 1967), Chapter I.

[2] Central Agency for Public Mobilization and Statistics, U.A.R., *Evaluation of the Population of the U.A.R.*, November 1967, p. 3 (Arabic).

[3] U.A.R. press releases.

[4] Personal communication with the Institute of Statistical Studies and Research, Cairo.

[5] Malek M. El-Nomrossy, "Statistical Report," (Unpublished paper), 16 December 1966, p. 15.

[6] United Nations, *Demographic Yearbook, 1967*, (New York: United Nations, 1968) p. 233.

[7] Haifaa Shanawany, "Family Planning: An Equilibrium Response to Demographic Conditions in the United Arab Republic (Egypt)," (unpublished Ph.D. dissertation, Cornell University, 1967), p. 21; Central Agency for Public Mobilization and Statistics, *Statistical Handbook of the U.A.R., 1952–1967*, p. 7.

[8] Abdel Fatah Farah, *Rural Population in the U.A.R.*, Statistical Department, Cairo, 1963, p. 6, cited by Shanawany, *op. cit.*, p. 64.

[9] Central Agency for Public Mobilization and Statistics, U.A.R., *U.A.R. Statistical Atlas, 1952–1966*, p. 10.

[10] United Nations, *op. cit.*, p. 208.

tries does not seem to obtain in the U.A.R. Shanawany [11] cites studies by Cleland (1906–early 1930's), Kiser (1931 data), and El-Badry (1947), none of which found a rural/urban fertility differential. Zikri's study (1960) actually found a higher urban fertility rate. Shanawany also mentions Rizk's study of 2,000 urban, almost 700 semi-urban and 3,000 village women (reported in Rizk's dissertation, 1959). Rizk found the rural/urban difference in number of live births was not statistically significant.

Religious Composition

The distribution of population by religion has remained rather constant throughout this century. Excluding the frontier districts, which accounted for 1.1 per cent of the population, the religious distribution in 1960 was as follows: Moslem, 92.2 per cent; Christian, 7.5 per cent; and Jewish, 0.3 per cent.[12]

The average number of live births for urban and rural Moslems and rural Christians is quite similar, 7.07, 7.61, and 7.44 respectively. However, urban Christians have an average of 5.54 live births.[13]

Age at Marriage

Data available on age of marriage are quite conflicting. Zikri[14] reports that the average for women was 20.3 in 1947 and 19.2 in 1960. However, computing medians from age distribution data in the 1960 census results in a median age at last birthday of 25.6 for bachelors marrying spinsters and 17.25 for spinsters marrying bachelors.[15] Analysis of the frequency distribution of age of marriage for men reported by the UN results in a median of 27.75 in 1966.[16]

Literacy

Although the literacy rate for the U.A.R. is low, particularly for females, it did rise gradually from 1927 to 1947 and took a sharper upward turn in the 1960 census. The latter is probably the result of increased emphasis on education in recent years. In 1960 the literacy rate for men was 44.8 per cent and for women 16.4 per cent.[17] Children below ten years of age were not included in these figures. Urban/rural comparisons are not available for 1960, but in 1957 the urban literacy rate for males was twice as great as for their rural counterparts and the rate for urban women was four times as great as for rural women.

Future Trends

The latest government figure for population growth is 2.54 per cent but it is likely that the actual growth rate is closer to 3.0 per cent. It is hoped that the rate can be reduced to 1.7 per cent by 1975. If the rate of 1.7 per cent could be achieved immediately, and maintained, there would be 45.0 million people in 1988; if the rate of 3.0 per cent continues there would be 58.35 million by 1988.

The life expectancy at birth for men rose from 35.65 in 1936–38 to 51.6 in 1960; for women it rose from 41.48 to 53.8.[18] These changes without a comparable decrease in birth rate have resulted in the very high ratio of 95 people in the non-productive age group for every 100 people in the productive age group (15–59) in 1960.[19]

Population Growth and Socio-Economic Development

Relationship to National Income

The growth of population from almost 13 million in 1917 to almost 22 million in 1952 resulted in a sharp decline in per capita income because the economy did not develop at a comparable rate. Many changes, which arrested this trend, took place in the economy following the revolution in 1952. The 1952 per capita income of $86.00 increased by 36 per cent during the next eight years. At constant prices the annual compound rate of growth in per capita income was 2.37 per cent[20], and from 1959–60 to 1964–65 it was 3.9 per cent.[21]

Relationship to Size of Labor Force

From 1960 to 1965 the labor force increased from 6 million to 7.3 million but, considering the population growth, this only represented an increase from 23 per cent to 25 per cent of the total population. The per cent employed in agriculture decreased from 54.3 to 51.5 while the percentage in the industrial sector increased from 10.2 to 11.2.[22] It has been estimated that the annual addition to the manpower pool is 27 times the number of industrial workers that can be absorbed.[23]

Relationship to Agriculture

Land reform was one of the main socio-economic changes that took place after 1952. Although the new government may have been successful in redistributing the agricultural wealth, it had a negative effect on mitigating the problems of overpopulation. It resulted in increased unemployment because many families previously employed, or under-employed, by large landowners as permanent or casual laborers could not find employment with the new class of landowners whose small holdings could be cultivated by the owner-family.[24]

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[11] Haifaa Shanawany, "Overall Aspects of the Population Problem in the U.A.R. (Egypt)," pp. 9–10. (Mimeographed.) A shorter version of this paper was published in *Mid-East*, September–October 1968.

[12] S.O.P. Press, *Vital Statistics*, Cairo, 1961, pp. 86–87, cited in Shanawany's dissertation, *op. cit.*, p. 80.

[13] Hanna Rizk, "Patterns of Fertility in Selected Areas in Egypt," (unpublished Ph.D. dissertation, Princeton University, Princeton, N.J., 1959), pp. 48, 106, cited in Shanawany's dissertation, *op. cit.*, pp. 81–82.

[14] Abdel-Khalik M. Zikri, "Socio-Cultural Determinants of Human Fertility in Egypt, U.A.R.," (unpublished Ph.D. dissertation, Syracuse University, Syracuse, N.Y.) p. 114.

[15] Department of Statistics and Census, *Vital Statistics, 1960*, Vol. II, Cairo, 1963, pp. 290–91.

[16] United Nations, *op. cit.*, p. 749.

[17] Central Statistical Committee, *Basic Statistics*, (Cairo S.O.P. Press, 1962), p. 176, cited in Shanawany's dissertation, *op. cit.*, p. 198.

[18] United Nations, *op. cit.*, p. 708.

[19] *Ibid.*, p. 148. Based on population by age distribution.

[20] Magdi M. El-Hammash, "An Analysis of the Process of Development of the Egyptian Economy with Special Reference to the Supply Approach to Economic Development," (unpublished Ph.D. dissertation, Duke University, Durham, N.C., 1965) p. 335, cited in Shanawany's dissertation, *op. cit.*, p. 95.

[21] Ali Sabri, *Sanawat El Tahoul El Ishtiraky Wa Takeem al-Khita al-Khammassia al-Aula* (Cairo: Dar El Marrif, 1966), pp. 56–61, cited in Shanawany's dissertation, *ibid.*, p. 96.

[22] Ali Sabri, *ibid.*, p. 74, cited in Shanawany's dissertation, *ibid.*, p. 97.

[23] Attributed to Hanna Rizk, reference not available.

[24] Shanawany's dissertation, *op. cit.*, p. 98.

From 1937 to 1965 the population increased by 84.5 per cent, while the production of staples changed as follows: wheat, +21 per cent; beans, +18 per cent; rice, +180 per cent; maize, −7 per cent.[25]

The Aswan High Dam will add two million acres to the six million acres previously under cultivation. However, the population increased by 23 per cent during the construction of the dam, a period that does not include the time needed to bring all of the additional land under cultivation. From 1877 to 1960 (when construction of the High Dam began) the land under cultivation increased by 26 per cent while the population more than tripled.[26]

Relationship to Social Welfare Expenditures

Information on the changes in expenditure for education and health is not readily available; however, one can obtain some idea of the change from the increase in services. From 1953–54 to 1966–67, while the population increased by 50 per cent, the number of classrooms and teachers and the bed capacity of hospitals almost doubled.[27]

Population Policy

Shanawany[28] has divided the development of a population policy into four stages: the stage of indifferent awareness (1922–51); the stage of experimentation (1952–61); the beginning of a population policy (1962–65); and the stage of attempted coordination (1966–). The latter stage had just begun at the time of her writing. The Presidential Decree promulgated on 13 November 1965 established the Supreme Council for Family Planning. This was followed by the beginning of the national family planning program in February 1966.

Although the Government, since 1953, shifted back and forth in terms of support for family planning and in its attitude toward population as an asset or a liability, most of the statements by President Nasser in the sixties were in favor of family planning and opposed to rapid population increase.

Through its various channels of communication the Revolutionary Government brought hope to the people, but the resulting expectations rose much faster than the Government's ability to meet them. Also the extension of free medical care, increased employment, higher wages, and the redistribution of land fostered an increase in population. This increasing pressure on the government resulted in the following statement in the National Charter of the U.A.R., 21 May 1962:

> This [population] increase constitutes the most dangerous obstacle that faces the Egyptian people in their drive towards raising the standard of production in their country in an effective and efficient way.[29]

This statement can be regarded as the beginning of a national population policy. A variety of factors that contributed to its development are best summarized in President Nasser's later statement, "We must apply birth control because our requirements are more than the existing potentialities."[30]

The next paragraph in the Charter emphasizes the serious family planning effort that must be made, but it is not completely optimistic about the possibility of success:

> While the attempts at family planning to face the serious problem of increasing population deserve the most sincere efforts supported by modern scientific methods, the need for the most rapid and efficient drive towards increased production necessitates that this problem be taken into consideration in the process of production regardless of the effects which may result from the experiment of family planning.[31]

Although the Charter statement of 1962 marked the beginning of an official policy, it was the Presidential Decree of November 1965 and Prime Minister Zakaria Mohieddin's speech at the National Assembly the following month that marked the first step in translating policy into program. The Prime Minister's speech referred to a budget for a family planning program and the creation of the Supreme Council for Family Planning.

There has been considerable interest recently in emigration as a national policy. Traditionally the Egyptians have been one of the least migratory people. According to Shanawany it was estimated that 25,000 Egyptians lived abroad in 1937 and 100,000 in 1962.

> Following the Middle East conflict in 1967, a drastic change has taken place in government policy. Emigration has been encouraged openly in the press. . . . According to Abdel-Meguid El Abd, Head of the Central Organization of Training, in a report presented to the Council of Ministers, 9,379 persons migrated within a period of four months (January–April 1968), mostly to Arab countries. Out of these 1,342 had to return back because they did not find jobs.[32]

Shanawany does not see emigration as a solution to the population problem because it would require the emigration of 250,000 annually to bring about a radical reduction in population growth.[33]

Population Programs

Objectives

To date a comprehensive national plan for family planning has not been developed. In a less formalized way policies, objectives, targets, etc., have emerged from the meetings of the Supreme Council for Family Planning. However, because of the preoccupation with the military situation, no meetings were held from the time of the June War in 1967 until the first part of 1969 when a new chairman was appointed for the Council.

It was not until 1967 that growth

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[25] Central Agency for Public Mobilization and Statistics, *Statistical Atlas*, *op. cit.*, pp. 39–51.

[26] F. Hefnawi and A. Hanafi Mahmoud, "Attempts Towards the Control of Population Problem in Egypt," (unpublished paper, 1968) p. 2.

[27] Central Agency for Public Mobilization and Statistics, *Statistical Handbook, 1952–1964*, pp. 128–133; and *Statistical Handbook, 1952–1967*, pp. 170–173.

[28] Shanawany's dissertation, *op. cit.*, p.134.

[29] *The Charter* (Cairo: Information Department, U.A.R.), p. 61 (English translation).

[30] Gamal Abdel Nasser, *Address at the Popular Rally at Suez on the Occasion of its National Day* (Cairo: Ministry of National Guidance, 22 March 1966) p. 15, cited in Shanawany's dissertation, *op. cit.*, p. 236.

[31] *The Charter*, *loc. cit.*

[32] Shanawany, "Overall Aspects of the Population Problem," *op. cit.*, p. 12.

[33] *Ibid.*, p. 12.

rate targets were established: 2.35 per cent in 1968; 2.25 per cent in 1969 and 2.1 per cent in 1970.[34] Various undocumented references cite a growth rate of 1.7 per cent as the goal for 1975; however, the targets mentioned were established prior to the war in 1967 and did not anticipate the resultant disrupting effect upon the program. In early 1969 interest in the program was renewed and prospects for an acceleration of effort increased.

There has been some interest in social change as a means of lowering the growth rate and a new marriage law was drafted to raise the minimum age for marriage from 18 to 25 for men and from 16 to 18 for women, but as yet it has not passed.[35]

ORGANIZATION

Structure. The Presidential Decree of 13 November 1965 established the Supreme Council for Family Planning, chaired by the prime minister and composed of eight ministers and the head of the Central Agency for Public Mobilization and Statistics. The Supreme Council is the policy-making body and its decisions after approval are final and effective for all ministries, governorates and other governmental organizations. The Council is freed from all rules and regulations applied to other governmental departments, particularly those pertaining to personnel, salaries and overtime.

Reporting to the Council is the Chairman of the Executive Board who is assisted by three general departments: (1) Department of Technical Affairs; (2) Department of Provincial Executive Bureaus, to which is attached the bureau in each of the twenty-five governorates and the approximately 2,700 (spring 1969) centers that provide family planning services; and (3) Department of Financial and Administrative Affairs.

In addition, the Executive Board has three advisory committees: (1) Medical and Training Committee to sponsor studies related to family planning methods and to advise on media; (2) Statistical and Demographic Research Committee, responsible for social and statistical research; and (3) Guidance and Publicity Committee for disseminating the aims and values of family planning and organizing the ways and means of doing this. General and special committees can be formed by the chairman of the Executive Board from the membership of these committees.

Location Within the Government. The U.A.R. is divided into twenty-five governorates. In 1966 the Prime Minister decreed that governorate level family planning committees were to be formed and chaired by the governor with representation from several governmental departments and the private sector. The family planning committees are charged with executing the decisions of the Supreme Council's Executive Board, studying the suggestions given on family planning at the governorate level and locating difficulties that prevent the execution of the plan and overcoming such difficulties or suggesting solutions to solve problems at the local level.

The governorate executive bureau (one in each governorate) has the director of health as the president; the director of the executive bureau of family planning is the administrator. Membership consists of representatives of several governmental departments. The bureau is responsible for coordinating the work of the Executive Board and the Governorate Board for Family Planning, implementing regulations of the Executive Board, and supervising and inspecting units administering family planning services in the governorate.

At the beginning of the program in 1966 (February) there were 1,991 centers for family planning services. By October 1968 there were 2,667 centers.[36] These centers are located so that they are within walking distance of two-thirds to three-fourths of the population. The government plans to increase the number of centers so as to serve all of the people, but during the interim it hopes to provide medical and family planning service through mobile clinics.

OPERATIONS

Policy-making, targets, methods of implementation and similar coordinating functions are carried out at the national level. Implementation of the program and the day-to-day supervision is at the governorate level. Although some feel the main emphasis should be on a postpartum program, this is only one aspect of the total family planning program that includes all health facilities. Primary importance is given to the oral pill with the IUD receiving secondary emphasis. The IUD program is mainly urban, as only 17 of the 500–600 physicians trained for IUD insertion are in rural facilities.

Methods. At present oral contraceptives and IUDs are the only methods offered through the National Family Planning Program clinics; the IUDs are only offered in about one-fifth of the clinics, primarily urban. It is anticipated that more physicians will be trained in the fall of 1969 for IUD insertion, which will make this method available to a much larger segment of the population. IUDs and oral contraceptives are manufactured locally with imported raw materials. In addition to availability in the government operated clinics, the pills are also for sale at private pharmacies for 20.5 piastres ($.47) per cycle. The plan has been to have a six-month reserve supply of oral contraceptives. However, this has become increasingly difficult to maintain because of the shortage of foreign exchange.

Abortions and sterilizations may be done to save the life of the mother, but neither are part of the family planning program. Recent registrations from two university hospitals report two births for each abortion. Injectibles are being used in research programs as are various types of IUDs. Condoms are available through shops and pharmacies but receive very little promotion and are not manufactured locally. Clinics operated by the Egyptian Family Planning Association provide other types of contraceptives, and it is anticipated that all health facilities will offer several different types in the near future.

[34] Malek Mohamed El-Nomrossy, "The National Family Planning Project, October 1965–December 1967," pp. 126, 139 (unpublished paper).

[35] Appendix of a paper prepared by the Rule of Law Research Center, Duke University, U.S.A. on family planning in the U.A.R. Date unknown, but after 1965.

[36] Malek M. El-Nomrossy, "The Population Problem and the National Family Planning Program in the U.A.R.," (Mimeographed) p. 6.

Budget. The budget for 1968–69 was LE 800,000 ($1,840,000). This was used for the purchase of raw materials and the manufacture of contraceptives, payment of incentives, publicity, part-time salaries and the operating expenses of the program. Expenses not included in this, but which should be considered as part of the contribution of the government toward the program, would be part of the cost of building and maintaining the units that provide family planning services in addition to other services.

Health facility personnel are not paid for their additional three afternoons of family planning work per week except for what might be called a commission. The charge to the client for oral pills is 10 piastres ($.23), which is divided between the doctor (50 per cent or 60 per cent depending upon whether urban or rural) and other health facility staff. The staff also receive LE 1.000 ($2.30) for each IUD inserted that remains in place for one month. This is divided in similar fashion. In addition, each person who recruits an IUD client receives 50 piastres ($1.15). Quite often this goes to the social worker.

Personnel. Most of the medical and para-medical workers in the family planning program are not recruited specifically for the program, as they are already employed by the health ministry. Regular clinical personnel (physicians, nurses, social workers and helpers) in each health facility are expected to work three afternoons a week beyond the official clinic hours. The administrative line of authority is with the Ministry of Health and not with the National Family Planning Program's Executive Board.

Some of the top administrative personnel of the National Family Planning Program have full-time responsibilities in other positions and receive 30 per cent additional salary for time devoted to family planning. During the first year of the program, 98 per cent of the personnel who were working in family planning were assigned to family planning work on a part-time basis from other governmental departments.[37] In December 1967 there were 3,000 doctors, 1,200 social workers and 1,300 nurses and midwives working in the program.[38]

Five-hundred to six-hundred physicians have been given specific training for IUD insertion; all physicians received some training in reproductive biology and contraceptive technology while assigned to the obstetrics and gynecology section as part of their internship. However, neither social workers nor nurses have received any training in family planning beyond what they may have received in their academic education and on-the-job experience. Some training has been provided to personnel working in data collection in the governorates.

Research and Evaluation

Various studies have been done to learn more about the characteristics of acceptors and their experience with contraceptives but these studies are not done on a regular basis. There are no data on continuation rates for IUD or pill users that allow for international comparison.

Accomplishments. From February 1966, when the program began, until October 1968 the number of health facilities offering family planning services expanded from 1,991 to 2,667.[39] By October 1968 the Government reported that 88,144 IUDs had been inserted (about 85,000 in urban areas), and that there were 254,437 continuing users of oral contraceptives.[40] In addition 100,000 IUDs have been distributed to private clinics, and it is estimated that 50,000 of these have been inserted.[41] In 1967, 800,000 cycles of oral contraceptives were reported to be sold through private pharmacies and in 1968 this had increased enough to supply 120,000 women.[42]

It is difficult to translate these figures into number of births prevented. The best one can do is to estimate that, if all of these contraceptives were used by married women in the fertile age group, 2 per cent of them through the national program and 1 per cent through private clinics had an IUD inserted at some time during the first 21 months of the program. (IUDs were not available through the National Family Planning Program for the first six months.) There were 5.5 continuing users of oral contraceptives for every 100 married women in the fertile age group; and, if the monthly sale of the orals was constant throughout 1968, the comparable rate of continuing use of oral contraception in the private sector was 2.6 per 100. The average age of the oral contraceptive client was 33.2 years and the average number of living children was 4.6.

A study[43] of 62,298 women clients in 42 voluntary centers of the Cairo Family Planning Association noted the characteristics shown in Table 1.

The same study[44] reported a drop in birth rate from 58.1 to 31.6 and 54.3 to 37.1 from 1963–67 in two villages with family planning services and from 55.9 to 46.0 in a village without such service. The national

[37] Malek M. El-Nomrossy, "Statistical Report," 30 December 1966, p. 5 (unpublished paper).

[38] El-Nomrossy, "National Family Planning Project," *op. cit.*, p. 50.

[39] El-Nomrossy, "Population Problem," *op. cit.*, p. 15.

[40] *Ibid.*

[41] *Ibid.*

[42] *Ibid.*, p. 16.

[43] M.I. Ragab and M.B. Sammour, "A Socio-Medical Study on Sixty Thousand Women Attending for Family Planning," *Ain Shams Medical Journal*, Vol. 18, No. 2, October 1967.

[44] *Ibid.*, p. 79.

TABLE 1. *Characteristics of Family Planning Clients*

Characteristic	Urban Middle Class	Industrial Area	Urban Poor	Rural
Average age at clinic visit	28.5	30.7	30.2	32.1
Average age at marriage	21.3	17.5	18	16.9
Average number of pregnancies	6.6	9.2	12.7	13.3
Average number of living children	2.6	5.6	4.6	4.5
Average time period since last pregnancy (in months)	15.4	12.1	8.3	10.1
Number of respondents	19,420	8,396	16,903	5,328

birth rate declined gradually and steadily from 42.8 to 39.3 during the same period.

The oral contraceptive program had stabilized by December 1967 with only 8.6 per cent of those who attended being reported as newcomers.[45] "An analysis of the decrease of newcomers in the last two years (1966 and 1967) . . . indicates that the decrease depended entirely on the degree of activity undertaken by the social workers."[46]

Private Efforts[47]

The development of voluntary efforts in family planning in the United Arab Republic has been closely related to progress in the emancipation of women. As such, one can think of the beginning of the movement dating back to the early 1920's when Mrs. Hoda Shaarawi, founder of the Egyptian Feminist Union, challenged Egyptian society by throwing her veil into the Mediterranean.

In 1953 the new government established a high level commission, the National Committee for Population Problems, to undertake studies in demographic and other related aspects of the population problem with the objective of making recommendations on population policy. Toward the end of 1955 the Committee established and supervised eight family planning clinics in Cairo and Alexandria using the facilities of the voluntary organizations working in the field of social service. No publicity was allowed, and women heard about these clinics only by word of mouth. There was so much secrecy about the clinics that the press had no access to information on their activities. In 1957 the Committee was transferred to a non-governmental organization called the Egyptian Association for Population Studies, although financing continued through the Ministry of Social Affairs. Then this became the Egyptian Association for Family Planning, and the Alexandria Family Planning Society was founded in 1962. It was mainly late 1963 that the subject of family planning was brought out into the open, and the Cairo Women's Club started a series of lectures delivered in Egypt to non-medical people on the topic. The series provided an important source for information on family planning to reach the Egyptian newspapers. In April 1964 a group of 22 women's voluntary organizations joined forces to become active in family planning. They formed a Joint Committee of Women's Organizations which, after one year of trial using their own resources, was sponsored and financed by the Ministry of Social Affairs and international agencies, and set in operation 28 family planning clinics. By spring 1969, through the Egyptian Family Planning Association, the Ministry of Social Affairs was sponsoring 361 clinics. In 1968 the Egyptian Family Planning Association received LE 50,000 ($115,000) from the Ministry for general support and 30,000 Sterling ($72,000) from the Danish Government through the International Planned Parenthood Federation for medical equipment. Prior to the initiation of the National Family Planning Program the clinic staff of the Association had inserted approximately 18,000 IUDs. The Association has been active in keeping the need for family planning before the public, providing training for family planning workers and operating clinics.

Educational and Scientific Efforts in Population

The Central Agency for Public Mobilization and Statistics is responsible for the census and related activities. Organizations involved in research and training are the departments of obstetrics and gynecology and public health in the medical faculties, the Cairo Demographic Center, the Institute for Statistical Studies and Research, the Social Research Center of the American University in Cairo and the Egyptian Society for Population Research. Secondary schools include some discussion of the population problem in their geography course.

Foreign Assistance

Several international organizations have provided varying degrees and types of assistance. This has taken the form of fellowships and travel awards, advisors and consultants, vehicles, office and media production equipment, and support for research and training activities. Participating organizations are or have been: the Ford Foundation, the Population Council, the Pathfinder Fund, International Planned Parenthood Federation (IPPF), Cooperative for American Relief Everywhere (CARE), United Nations International Children's Emergency Fund (UNICEF), United Nations Development Program and the Government of Denmark.

Publications

Several Egyptian journals publish articles dealing with family planning, population, reproductive biology and contraceptive technology. Among these are: *The Egyptian Population and Family Planning Review*, *The Journal of Endocrinology and Metabolism*, *Gazette* of the Egyptian Society of Gynecology and Obstetrics, *Bulletin*, Alexandria Faculty of Medicine, *Ain-Shams Medical Journal*, *The Journal of the Egyptian Medical Association*, *The Egyptian Journal of Social Medicine*, *Proceedings* of the Egyptian Academy of Science, *Journal of the Egyptian Statistical Association*, *Proceedings* of the Egyptian Statistical Conference (annual), *Medical Journal* of Cairo University (incorporated with the *Gazette* of Kasr-El-Aini Medical Faculty), and monthly newsletters and other publications by the Egyptian Family Planning Association.

Summary

The United Arab Republic is quite fortunate in having a large network of health facilities through which family planning services can be provided. It has a strong and active voluntary association which operates clinics and does much to publicize the importance of family planning. The U.A.R. is unique among developing countries in that it has a large number of well trained, highly qualified professional people. The Minister of Public Health, appointed in February 1969, is a long-time friend of family plan-

[45] El-Nomrossy, "National Family Planning Project," *op. cit.*, p. 64.

[46] *Ibid.*, p. 70.

[47] The material in this section is based on discussions with Mrs. Aziza Hussein, President, Cairo Family Planning Association; Dr. Haifaa Shanawany, Director, Egyptian Family Planning Association; papers by these two ladies; and Dr. Hasan Husein's chapter in *Family Planning and Population Programs*, edited by Berelson *et al.*, (Chicago: University of Chicago Press, 1966).

ning and is highly respected in the professional community. It is expected that he will do much to revitalize the program. Transportation and communication are good. The Presidential Decree of 1965 is ideal in terms of establishing and giving sanction to the program and providing a legal basis for considerable flexibility in its implementation. Public health and obstetrics and gynecology faculties have taken and are continuing to take considerable responsibility for research and training in the medical aspects of family planning.

As is true of all family planning programs, the one in the U.A.R. has certain problems. The shortage of foreign exchange to purchase raw materials for the production of oral contraceptives could seriously damage the program by undermining the confidence of the users in the ability of the Government to guarantee a continuing supply. A client lost because of unavailability of pills will be a difficult one to bring back and can become a highly vocal opponent of the program.

Slowing population growth is perhaps more important to the economic future of Egypt than the construction of the High Dam. The efforts to achieve this control require just as much careful planning, good administration, setting of targets, evaluation of progress and training of personnel as was true for the High Dam. A national plan for family planning can provide the framework within which problems can be identified and the means of dealing with them implemented.

Full time staff is needed in the upper administrative echelons, and the director of the program must be high enough in the government hierarchy to have the freedom to make decisions and the power to enforce them within the policy limitations established by the Supreme Council.

Knowing the number who start contraceptive practice is important, but this has little meaning for number of births prevented unless continuation rates are known. The ultimate criterion of success is the lowering of the birth rate. Perhaps a population growth study is needed to obtain continuing feedback on the effects of the program and to obtain, on a sampling basis, a degree of accuracy that cannot be expected from a large national census. Other data of considerable value to the administrator, which are not obtained in a census, could also be gathered.

A full-time qualified training staff is required for the pre-service and in-service training of family planning personnel. Training should be continually available for new persons entering the program and, equally important, in-service training should continue so that family planning staff can be kept up to date on the latest developments in the field.

Too often mass media are equated with education. Mass media are important but there is considerable doubt that they can do any more than inform. Most people need education in addition to information. They need to learn why family planning is important to them and how it can help them to achieve their goals. This can best be done on a person-to-person basis. The clinic social worker should be trained to be more of a community worker so that she can recruit clients from the community, not just from the clinic.

Greater recognition needs to be given to the importance of men in the family planning program. Provision should be made for male methods of fertility control as well as educational programs that provide the husband with information and recognition of his known influence in determining whether his wife adopts and how long she continues to use contraceptives.

Epilogue

The preceding report reflects the status of the program as of spring 1969. It is anticipated that the next twelve months will see considerable improvement in the organization and implementation of the family planning program under the leadership of the present Minister of Public Health. A step in this direction was an all-day meeting on 7 June 1969 of the Egyptians who had visited family planning programs throughout the world and/or had studied family planning and population abroad; administrators of the Egyptian program; and religious, political, educational and other leaders. This meeting of more than 200 people was called by the Minister so that he could obtain their ideas on how the program could be improved. This will be followed by meetings of the Minister with smaller groups for more detailed discussion of the specific methods for improving the program.

Although this in itself will not solve the population problems in the U.A.R., such involvement of the most knowledgeable and best qualified people in the decision-making process is an important and constructive approach to revitalizing the program.

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